Maternal Mental Health (MMH) Program Description

carelon Behavioral Health

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I. Background

A. Maternal Mental Health

Issues surrounding maternal mental health have been widely studied and found to be prevalent and result in significant implications. In California, one in five women have depression, anxiety or both while either pregnant or during the postpartum period, with rates nearing 40% for low-income women. This can lead to decreased adherence to prenatal care, pre-term delivery, issues breastfeeding, increased risk of child abuse and neglect and long-term behavioral health risks for the child. Nationwide, the leading cause of pregnancy-related death is a mental health condition, including deaths to suicide and overdose/poisoning related to substance use. To address this issue, increased perinatal screening for depression and anxiety starting at the first prenatal visit, regularly during pregnancy, and at least three months postpartum is recommended, along with appropriate referral and follow-up.

B. Regulations

In recognition of the above issues, CA legislature implemented CA bill AB-2193 and more recently, SB-1207. AB 2193, enacted in July 2019, required health care service plans and health insurers to develop a maternal mental health program consistent with sound clinical principles and processes, as well as required licensed health care practitioners who provide prenatal or postpartum care to screen or offer to screen a mother for maternal mental health conditions. More recently, SB-1207, extended the deadline to establish the maternal mental health program to July 1, 2023, revised requirements to include quality measures to encourage screening, diagnosis, treatment, and referral. Additionally, the bill encourages plans to improve screening, treatment, and referral to mental health services, include coverage for doulas, incentivize training for obstetric providers, and educate enrollees about the program.

II. Service Model for the Maternal Mental Health Program

A. Program Overview

Carelon Behavioral Health has created a program around maternal mental health to support perinatal women. Referrals for the program can be received from providers already involved with a member or through self-referral. Physical Health (PH) and Behavioral Health (BH) providers, including Primary Care Providers, Obstetrics, Doulas, Pediatricians, and other specialists should screen members during routine appointments and refer identified members to the Carelon Case Management (CM) team. Referral forms will identify the population to link members during a first encounter or request for services. In addition to provider referral, members may call Carelon due to self-identified behavioral or maternal mental health needs. These members will be identified through Carelon Member Services and/or our call center. Staff will assist in providing appropriate network referrals and complete a referral to CM for care coordination services.

Our CM team supports the program by prioritizing MMH referrals for outreach and screening. These referrals will be opened under Care Coordination. Case Managers will focus on linking identified members to behavioral health providers and community resources with expertise in working with maternal mental health, as appropriate. They will work alongside members, assisting with their needs to overcome depression, substance use, or other mental health conditions impacting their lives. Additionally, Case Managers will help facilitate and improve coordination with the member's treatment team, which includes both physical and behavioral health providers.

B. **Program Goals & Objectives**

- Educate members and providers about maternal mental health conditions
- Increase screening, referral, diagnosis, and treatment of maternal mental health conditions
- Assist members in identifying resources and supports available from pregnancy through the first year of motherhood
- Link members to a behavioral health practitioner who is experienced in evidence-based treatment modalities for perinatal women
- Support members in addressing emotional issues that can arise during pregnancy and the first year of parenting, as well as developing/increasing coping skills
- Coordinate care between mental health and physical health treatment to address both psychosocial and physical issues at hand
- Increase outreach and engagement of existing providers with MMH specialty
- Collaboration with Plan on identification of members through maternity case management team, perinatal practitioners (Obstetricians, Gynecologists, Midwives, Pediatric and Adult Primary Care Providers), working with pregnant and postpartum individuals presenting with mental health and/or substance use concerns

C. **Case Management Services and Interventions**

To meet the above goals and objectives, the following case management services are provided:

- Member outreach and screening:
    - Social Determinants of Health (SDoH) – SDoH screening is done with every member referred to Case Management. Results will facilitate addressing social determinants of health, such as assisting women in enrolling in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Section 8 housing, enhanced transportation, childcare, job training and/or placement, or assistance in pursuing educational opportunities (e.g., General Equivalency Development, trade school, college)
    - PHQ-9 Assessment upon case opening and every 30-45 days, until member reaches case management care plan goals. The higher the score, the more symptoms of depression are experienced:

        - 0-4 points = "normal" or minimal depression
        - 5-9 points = mild depression
        - 10-14 points = moderate depression
        - 15-19 points = moderately severe depression
        - 20+ points = severe depression
    - Edinburgh Postnatal Depression Scale (EPDS) to assist in identifying mothers experiencing postpartum depression (PPD); can be used during pregnancy and up to 8 weeks after birth
        - Mothers scoring above 9 points are automatically referred
        - Scores below 9 may be referred based on additional case management assessment of needs
    - Members will also receive a self-scoring copy of the screening tools, along with a flyer on our program
    - Acute and urgent cases, with more intense case management needs, will be directly connected to a Mental Health Provider and/or OB or Primary Care Provider and followed more frequently by case management (standard crisis process will be followed, as needed)

- Linkage:
    - Case Managers will assist members with obtaining mental health services and follow-up with member ensuring they have connected with a provider and/or other resources
    - Assist with resources for housing, food, county supports, transportation
    - Provide comprehensive resources via email or mail, based off members' preference

- Collaboration with:
    - Health Plan and/or Medical Case Management
    - Members' current practitioners (&/or coordinate care for the member and baby, as needed)
    - Community providers to meet the members where they are, provide whole person care, support & resources
    - Community & faith-based organizations to reach underserved communities

- Education related to understanding:
    - Maternal Mental Health program & coverage of Doulas
    - The importance of attendance at perinatal follow-up appointments with OB/GYN and all pediatrician appointments for newborn infants
    - Support available to moms with premature births and caring for infants in the Neonatal Intensive Care Unit (NICU)

D. **Behavioral Health / Physical Health Integration**

Carelon staff collaborate with Health Plans and medical providers to ensure coordination and integration of behavioral and physical health. To promote this integration, Case Managers will work with the health plan and/or medical case

managers to:

- Ensure member is attending perinatal follow-up appointments & infant attendance at all pediatric appointment
- Coordinate when unsuccessful reaching member to ensure correct contact information

In addition to the above collaboration, Carelon offers:

- Interdisciplinary Rounds with medical case management teams to review complex cases, such as SUD during pregnancy, and ensure care is coordinated and integrated
- Case consultation and decision support from a Carelon licensed psychiatrist through our National Peer Advisor Line (877-241-5575)
- Provision of training to medical providers to increase awareness of maternal mental health issues, appropriate screening and referral

E. Network Identification & Development

Carelon will identify network providers that have experience working with evidence-based treatment modalities for maternal mental health issues including depression, anxiety, psychosis and trauma and providers who hold a Certification in Perinatal Mental Health. This will be done through a provider survey and review of the Perinatal Mental Health Provider Directory.

Carelon will also make additional training available to providers to increase knowledge of both the factors associated with maternal mental health, as well as best practice for managing this population. Further, there will be ongoing network outreach focused on having a robust panel of behavioral health providers who specialize in treating maternal mental health conditions. Providers who have competency in working with maternal mental health issues will be identified to ensure strong referral and linkage for members needing these services.

III. Training / Education

A. Providers

Carelon will support education and training for physical & behavioral health professionals by sponsoring a Maternal Mental Health and Substance Use Disorder training that will focus on:

- Prevalence & impact of maternal mental health conditions
- Risk factors for MMH Disorders
- Unmet treatment needs
- Screening and assessment
- Referrals
- Treatment

Training will be offered live by the Medical Director and Clinical Team and recorded and posted on the Carelon website. Training can be linked on the health plan website to ensure access for physical health providers. Training will be reviewed annually and

updated as needed.

Carelon will also provide education to our network of behavioral health providers, as well as support awareness of the maternal mental health program for physical health providers, with emphasis on perinatal practitioners. This will be done through newsletter articles, pamphlets, and resources posted to our provider facing website, provision of documents to the Health Plan, as well as supportive training by Provider Quality Managers (PQMs).

B. **Carelon Staff**
Carelon will provide annual clinical training to case management and clinical teams, to include education on the Doula benefit, understanding maternal mental health needs, and how to locate providers with MMH specialties to guide referrals.

C. **Members**
Resources related to the Carelon MMH program, including the Program Description and flyers, along with other resources about where to find help, will be posted to member-facing websites and can be linked to health plan websites upon request. Additionally, Case Managers can email or mail materials to members.

IV. Data

Carelon will track referrals to the Maternal Mental Health program that come from all referral sources. Information will be noted in the members' records. Data will be used to track and trend volume of referrals, referrals to Medical Case Management, member outcomes (based on PHQ-9 and or EPDS scores), and to inform network adequacy for this population.

Where data exchange is available, information can be shared to support Health Plan HEDIS measures of PND-E and PDS-E. PQM can also educate providers on HEDIS measures and improving the scores, with collaboration of the Plan. Data exchange could also include trigger reports to enhance/provide automatic triggers for CM intervention based on members receiving both pregnancy related services and behavioral health care.